an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American Institute of Real Estate Appraisers (MAI) and who is acceptable to the Department.

d) In determining the historical cost of assets where an on-going facility is purchased, the provisions of Medicare Provider Reimbursement Manual (HIM-15), Section 104.14 will apply.

e) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American Hospital Association Chart of Accounts for Hospitals.

(2) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(3) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

c. Gains and Losses on Disposition

Gains or losses on the disposition of depreciable assets used in the program are calculated in accordance with Section 130 and 132 of HIM-15. Disposition of a provider's depreciable assets which effectively terminates its participation in the program shall include the sale, lease or other disposition of a facility to another entity whether or not that entity becomes a participant in the program. The amount of gain on the disposition of depreciable assets will be subject to recapture as allowed by HIM-15.

d. Depreciation, interest, lease costs, or other costs are subject to the limitations stated in Section 2422 of HIM-15 regarding approval of capital expenditures in accordance with Section 1122 of the Social Security Act.

e. Facility costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

H. Non-Allowable Costs

1. Bad debts, charity, and courtesy allowances: bad debts on non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs.

2. Purchases from related organizations: cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related organizations and costs in the State's cost reports.

3. Return on equity capital.

4. Other cost and expense items identified as unallowable in HIM-15.

5. Interest paid on overpayments as per Medical Assistance Manual Section 307.

6. Any civil monetary penalties levied in connection to intermediate sanctions, licensure, certification, or fraud regulations.

IV. ESTABLISHMENT OF PROSPECTIVE PER-DIEM RATES

Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or the ceiling:

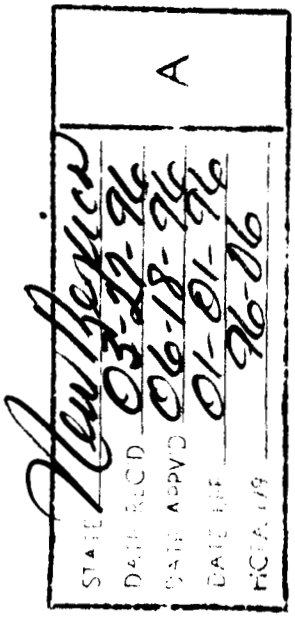
A. Base Year

Rebasing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as Year 1, Year 2, and Year 3. Because rebasing is done every three years, operating year 4 will again become Year 1, etc.

Cost incurred, reported, audited and/or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Rebasing of costs in excess of 110% of the previous year's audited cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

For implementation Year 1 (effective July 1, 1984) the base year is the provider's last available audited cost report prior to January 1, 1984.

Rebasing will occur out of cycle for rates effective January 1, 1996, using the provider's FYE 1994 audited cost report. The rate period January 1, 1996, through June 30, 1996, will be considered Year 1. The rate period July 1, 1996, through June 30, 1997, will be considered Year 2, and the rate period July 1, 1997, through June 30, 1998, will be considered year 3. The rebasing cycle will resume for rates effective July 1, 1998, and continue as described in the first paragraph of this section.



B. Inflation factor to recognize economic conditions and trends during the time period covered by the provider's prospective per diem rate.

The index used to determine the inflation factor will be the Health Care Financing Administration Nursing Home Market Basket Index (NHI).

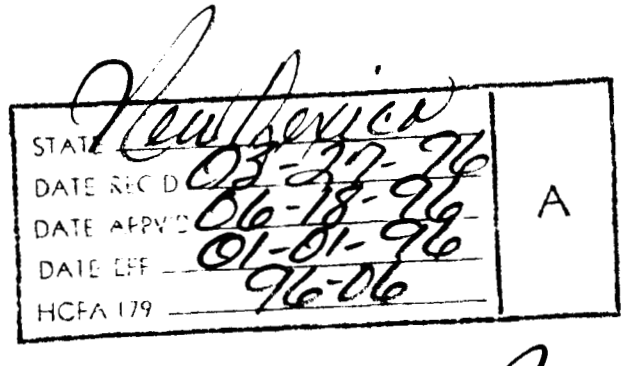
Each provider's operating costs will be indexed up to a common point of 12/31 for the base year, and then indexed to a mid-year point of 12/31 for operating Year 1. For the out of cycle rebasing occurring for rates effective January 1, 1996,

through June 30, 1996, the mid-year point for indexing for operating Year 1 will be 3/31.

The inflation factor for the period July 1, 1996, through June 30, 1997, will be the percentage change in the NHI for the previous year plus 2 percentage points. For each rate period thereafter, the inflation factor will be the change in the NHI for the previous year.

C. Incentives to Reduce Increase in Costs

As an incentive to reduce the increases in the costs of operation, the Department will share with the provider



SUPERSEDES: TN

in accordance with the formula described below the savings below the operating cost ceiling in effect during the state's fiscal year.

$I = [1/2(M - N)] \leq \$2.00$
Where
M = Current operating cost ceiling per diem
N - Allowable operating per diem rate based on the base year's cost report
I = Allowable incentive per diem

D. Calculation of the Prospective Per Diem Rate

The following formulas are used to determine the prospective per diem rate:

Year 1

$PR = BYOC \times (1 + NHI) + I + FC$

Where

PR = Prospective per diem rate
BYOC = Allowable base year operating costs as described in A above, and indexed as described in B above.
NHI = The change in the NHI as described in B above
I = Allowable incentive per diem
FC = Allowable facility costs per diem

Years 2 and 3

$PR = (OP + I) \times (1 + NHI) + FC$

Where

PR = Prospective per diem rate
OP = Allowable operating costs per diem
I = Allowable incentive per diem
NHI = The change in the NHI as described in B above.
FC = Allowable facility costs per diem

E. Effective Dates of Prospective Rates

Rates are effective July 1 of each year for each facility.

F. Calculation of Rates for Existing Providers that do not have 1983 Actuals, and for Newly Constructed facilities entering the program after July 1, 1984

For existing and for newly constructed facilities entering the program that do not have 1983 actuals, the provider's interim prospective per diem rate will become the sum of:

1. The applicable facility cost ceiling.
2. The operating cost ceiling.

After six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report. This will be audited to determine the actual operating and facility cost, and retroactive settlement will take place. The provider's prospective per diem rate will then become the sum of:

1. The lower of allowable facility costs or the applicable facility cost ceiling

2. The lower of allowable operating costs or the operating cost ceiling

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.

G. Changes of provider by sale of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The lower of allowable facility costs determined by using the Medicare principles of reimbursement, or the facility cost ceiling.

2. The operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.

H. Changes of provider by lease of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The lower of allowable facility costs or the facility cost ceiling, as defined by this plan.

2. The operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher.

Such providers will not be eligible for incentive payments until the next operating Year 1, after rebasing.

I. Sale/leaseback of an existing facility

When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

J. Replacement of an existing facility

When an existing facility is replaced, the provider's prospective rate will become the sum of:

1. The lower of allowable facility costs or the facility cost ceiling as defined by this plan.

2. The operating cost plus incentive payment paid to the provider prior to the construction of the replacement facility.

K. Replaced facility re-entering the Medicaid Program

When a facility is replaced by a replacement facility and the replaced facility re-enters the Medicaid program either under the same ownership or under different ownership, the provider's prospective rate will become the sum of:

1. The median operating cost for its category.

2. The lower of allowable facility costs or the applicable facility cost ceiling.

Such providers will not be eligible for incentive payments until the next operating year 1, after rebasing.

L. Closed facility re-entering the Medicaid Program

1. When a facility has been closed and re-enters the Medicaid Program under new ownership, it shall be considered a change of ownership and either G or H, which ever is applicable, will apply.

2. When a facility has been closed and re-enters the Medicaid program within 12 months of closure under the same ownership, the provider's prospective rate will be the same as prior to the closing.

3. When a facility has been closed and re-enters the Medicaid program more than 12 months after closure, under the same ownership, the provider's prospective rate will be the sum of:

   a) the median operating cost for its category
   b) the lower of allowable facility costs or the applicable facility cost ceiling.

Providers of such facilities will not be eligible for incentive payments until the next operating year 1, after rebasing.

V. ESTABLISHMENT OF CEILINGS

The following categories are used to establish ceilings used in calculating prospective per diem rates:

1. State-owned and operated NF
2. Non-state-owned and operated NF

The Department determines the status of each provider for exclusion or inclusion in any one category.

Ceilings will be separately established for each category as described above, and separately established for the two areas of allowable costs, i.e. operating costs and facility costs. The operating cost ceiling will be calculated using the base year costs for Year 1. For Years 2 and 3, the operating cost ceiling will not be recalculated. It will be indexed forward using the appropriate inflation factor. The

facility cost ceiling of $11.50 will be trended forward in Year 2 beginning July 1, 1985, by NHI minus 1 percentage points and then annually by the NHI.

A. Operating Costs

The ceiling for operating costs will be established at 110% of the median of allowable costs for the base year, indexed to 12/31 of base year.

B. Facility Costs

For existing, replacement, and newly constructed facilities, including remodeling of a facility to become a long term care facility, facility costs will be limited as follows:

1. Any facility that is participating in Medicaid by July 1, 1984, or has been granted Section 1122 approval by July 1, 1984, for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the applicable facility cost ceiling for implementation Year 1. The facility cost ceiling will be eleven dollars and fifty cents ($11.50).

2. Any new facility not approved July 1, 1984, under Section 1122 for construction (including bed additions to such facilities) will be paid the lower of actual allowable facility costs or the median of facility costs for all other existing facilities which are in the same category.

3. Effective for leases executed and binding on both parties on or after January 1, 1988, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor an annual rate of return on the fair market value of the facility equal to one time the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for the twelve months prior to the date the facility became a provider in the New Mexico Medicaid program. The rates of interest for this fund are published in both the Federal Register and the Commerce Clearing

STATE New Mexico
DATE REC'D MAR 31 1992
DATE APPV'D APR 05 1993
DATE EFF APR 01 1992
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House (CCH). The basis of the total investment will be subject to the limitations described in 1 and 2 above.

The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective and the reasonableness of such clauses will be determined by the inflation factor described in section IV, B, of these regulations.

Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider and is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with the geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the Department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the Department.

4. For newly constructed facilities, reconstruction of a facility to become a long term care facility, and replacement facilities entering the Medicaid program on or after January 1, 1988, the total basis of depreciable assets shall not exceed the median cost of construction of a nursing home as listed in the Robert S. Means construction index, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to enter the New Mexico Medicaid program. The costs of construction referred to herein is expected to include only the cost of the building and fixed equipment. A reasonable value of land and major moveable equipment will need to be added to obtain the value of the entire facility.

5. When an existing facility is sold, facility costs per day will be limited to the lower of:

   a. Allowable facility costs determined by using the Medicare principles of reimbursement or